

Member Prescription Reimbursement Claim Form

For pharmacy claims only. Please complete one form per member, per pharmacy.



A product of AmeriHealth Caritas Indiana, Inc.

Information and directions

1. To request reimbursement, please submit the following to the address listed at the bottom of this form. (Any missing information may result in delay or denial of the request.)
 - a. This completed and signed claim form
 - b. Proof of prescription purchased. Include one of the following:
 - Patient history printout from the pharmacy, signed by the pharmacist
 - Prescription receipt that includes all information listed here:

– Pharmacy name and address	– Quantity
– Date filled	– How much a day's supply is
– Drug name, strength, and National Drug Code (NDC) number	– Price
– Rx number	– Member's name
2. Reimbursement will be sent to the plan subscriber (policyholder) at the address AmeriHealth Caritas Next has on record. To view your address on record, please log on to **amerihealthcaritasnext.com/in** or call Member Services at **1-866-828-0092 (TTY 711)**.
3. **Retain a copy of all receipts and documentation for your records.**

Please note: You cannot be reimbursed if:

- You were not eligible for pharmacy benefits when you paid for the medicine.
- You were not an AmeriHealth Caritas Next member when you got the medicine filled.
- The prescription(s) you were seeking reimbursement for was (were) purchased from an out-of-network pharmacy for a nonemergency event.

Checklist

1. I have completed and signed this form in its entirety.
2. I have enclosed the documents requested above.
3. I have made a copy of all receipts and documentation for my records.

Document submission

Please submit this form and all documentation to:

AmeriHealth Caritas Next
P.O. Box 516
Essington, PA 19029

Member Prescription Reimbursement Claim Form



Member details

Subscriber information

Last name:

First name:

Middle initial:

Date of birth:

Member ID number (subscriber ID and suffix):

Gender:

Phone number:

Alternate phone number:

Mailing address:

Street address, city, state, and ZIP code

Patient information — Check here if same as above. ☐

Last name:

First name:

Middle initial:

Date of birth:

Prescription information

Prescribing physician(s)' name:

Prescribing physician(s)' address:

Prescribing physician(s)' phone:

Total amount spent at the pharmacy:

Number of prescriptions filled:

Detailed reason for the request. (Be specific.) If an out-of-network pharmacy was used due to an emergency event, please provide explanation and/or documentation of the nature of the emergency with all of the documentation for reimbursement.

Disclaimer

AmeriHealth Caritas Next complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AmeriHealth Caritas Next does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. I attest that the above information is true and accurate and that the medications were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be canceled and I may be subject to criminal and/or civil penalties for false health care claims.

I understand that reimbursement payment will be made to the plan subscriber and will contain information about the service (e.g., provider name, date, description of service). I also understand that AmeriHealth Caritas Next may request any additional information it deems necessary to verify that services were received and payment was made.

Name (print):

Signature:

Date:

Personal representative:

Please submit this form and all documentation to: AmeriHealth Caritas Next, P.O. Box 516, Essington, PA 19029